Rev 08/16/01

Department of Veterans Affairs

Registration Form

Employee Education System

TITLE OF PROGRAM: **Care Coordination and the Caregiver Forum**

LOCATION OF PROGRAM: Natcher Conference Center National Institutes of Health
Building 45, Center Drive, 9000 Rockville Pike
Bethesda, MD 20815 Telephone: 301-496-9966

PROGRAM DATE(S): **January 25-27, 2006** **PROGRAM NUMBER:** **06.ST.CC.JANCONF.A**

CONTACT PERSON: **Name: Cheri Phillips Phone: 314-894-6648 x6-3822 Fax: 314-894-6506**
Email: Cheri.Phillips@LRN.va.gov

REGISTRATION INSTRUCTIONS

1. Download a copy of this form to your personal computer (under FILE, click on SAVE AS, specify SAVE IN destination on your personal computer, click SAVE).
2. Follow your local approval procedures before registering for this program.
3. Participants from TEMPO II sites must also provide this information to EES to complete course registration.
4. Email or Fax completed registration form to the EES contact person listed above.
5. If travel is required to attend this program, funds must be provided by your facility/VISN.
   - Your travel clerk will need to prepare your travel authority (SF-3036).
   - Obtain your travel authority (SF-3036) and advance of funds.
   - Obtain a traveler's itinerary worksheet from your travel clerk.

REGISTRATION DEADLINE:
January 11, 2006

Employee Education Resource Center
#1 Jefferson Barracks Drive (14B-JB)
Building 2, Room 115
St. Louis, MO 63125

PARTICIPANT INFORMATION *(Please type or print clearly)*

Name: *First* | *MI* | *Last*

SSN*: ☐ **Sex:** ☐ Male ☐ Female

Job Title: *(40 spaces max)*

Professional Degree(s): *As it should appear on your certificate* *(15 spaces max)*

Occupational Category: ☐ Administrative ☐ Associated Health ☐ Physician ☐ Dentist ☐ Nurse

Employer Category: ☐ VHA ☐ VBA ☐ NCA ☐ Other Federal ☐ Non-Federal

Accreditation/Contact Hours Requested: *See program brochure for description of Continuing Education Hours and type of credit offered -* ***You must attend 100% of the program and complete the evaluation to receive credit for your attendance.***

☐ ACCME ☐ ACHE ☐ ANCC ☐ ASWB

Social Worker License Number (if applicable) _____

Facility/Org Name:		**Facility #**
Mailing Address:		**VISN #**
City / State / Zip:		
Service / Dept:		**Mail Routing Symbol (VA):**
Phone:		**Fax:**
E-mail Address:		**Pager:**

ALTERNATE NAME BADGE: (*If the name and/or organization should be different on name badge, please indicate below)*

Name: *First* | *MI* | *Last*

Organization:

While at program, name & number to call in event of an emergency: *(Required)*

Name:	*Day #:*	*Eve #:*

Please describe any special arrangements due to physical limitation(s) and/or special dietary requirements:

***PRIVACY ACT STATEMENT**

1. AUTHORITY: Title 50, Appendix, U.S.C., Title 10, U.S.C., Public Law 96-357 96th Congress, September 24, 1980 (Amendment to 10 U.S.C. 2107). 2. PRINCIPAL PURPOSE(S): To develop policies and procedures, compile statistics and render analytical reports, and, to track participation in EES activities. 3. ROUTINE USES: The information provided on the application will be used to maintain data on EES activities, provide requested reports on participation, and to provide activity original and duplicate certificates to EES activity participants.

4. MANDATORY AND VOLUNTARY DISCLOSURE AND EFFECT ON INDIVIDUAL PROVIDING INFORMATION: Disclosure of information requested in the EES registration form (the application) is voluntary; however, the information must be furnished in order for the applicant to receive a certificate of completion for EES activities and appropriate education credit.

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COMPLETE THIS SECTION IF SUPERVISOR APPROVAL IS REQUIRED FOR REGISTRATION

I certify that the funding is available to send the participant to the course, and that the participant has the time available to attend the course.

Participant Signature

Supervisor Signature

Date

Date

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